TEMPLE OR RISHON
2007-2008 SCHOOL REGISTRATION 5768

STUDENT INFORMATION

Student A

NAME____
LAST FIRST MIDDLE

M___ F___ DATE OF BIRTH_______________ HEBREW NAME_________________________________

CLASS AT TOR:
SUNDAY ONLY: PRE-K___ K___1___ $245___

2___ 3____ $405___
Book Fee $20___

SUNDAY/WEDNESDAY: 4/ALEPH 5/BET 6/GIMEL 7/DALET $485___
(Please circle Religious School and Hebrew Class Levels) Book Fee $25___

BAR / BAT MITZVAH FEE $590___

PAYMENT WILL BE BY: _____ SINGLE PAYMENT AT BEGINNING OF YEAR (PAID IN FULL)

_____ CREDIT CARD (MONTHLY/QUARTERLY) _____AUTODEBIT FROM ATM (DEBIT) CARD (MONTHLY/QUARTERLY)

Student B

NAME____
LAST FIRST MIDDLE

M___ F___ DATE OF BIRTH_______________ HEBREW NAME_________________________________

CLASS AT TOR: PRE-K___ K___1___ $245___
SUNDAY ONLY

2___ 3____ $405___
Book Fee $20___

SUNDAY/WEDNESDAY: 4/ALEPH 5/BET 6/GIMEL 7/DALET $485___
(Please circle Religious School and Hebrew Class Levels) Book Fee $25___

BAR / BAT MITZVAH FEE $590___

Please feel free to come and volunteer in our school. It will make your students day.

TOTAL DUE $_____________

PARENT INFORMATION
IF SEPARATE HOUSEHOLDS, STUDENT LIVES WITH: BOTH___ PARENT A___ PARENT B___
IF SEPARATE HOUSEHOLDS, SEND MAIL TO: BOTH___ PARENT A___ PARENT B___

PARENT A	PARENT B
NAME________________________________	NAME________________________________
ADDRESS_____________________________	ADDRESS_____________________________
CITY______________________ZIP__________	CITY______________________ZIP__________
DAY PHONE___________________________	DAY PHONE___________________________
WORK PHONE__________________________	WORK PHONE__________________________
CELL PHONE___________________________	CELL PHONE___________________________
PARENT E-MAIL________________________	PARENT E-MAIL________________________

EMERGENCY CONTACT: ONE OF THE FOLLOWING WILL BE NOTIFIED IF BOTH PARENTS ARE UNREACHABLE, OR IF A CHILD HAS NOT BEEN PICKED UP AT END OF SCHOOL:

NAME________________________________	NAME________________________________
RELATIONSHIP________________________	RELATIONSHIP________________________
HOME PHONE_______________CELL__________	HOME PHONE _____________CELL__________

EMERGENCY RELEASE INFORMATION
(ALL INFORMATION IS KEPT STRICTLY CONFIDENTIAL)

STUDENT NAME___________________________
LIST ANY LONG-TERM MEDICATIONS
____
DOSAGE________CONDITION_______________
WILL IT BE TAKEN AT SCHOOL? Y___ N___
MANNER ADMINISTERED___________________
CAN CHILD ADMINISTER? Y___ N___
IF NO, WHO CAN?__________________________
OTHER HEALTH INFORMATION:
___NO KNOWN HEALTH PROBLEMS
___ASTHMA
___EPILEPSY
___HEART CONDITION
___VISION PROBLEMS
___HEARING PROBLEMS
___ALLERGIES
FOODS______________________________
MEDICATIONS_______________________
BEE STINGS________________________
TREATMENT NEEDED________________
___ADD / ADHD___________________________
___OTHER (PLEASE SPECIFY)
____
___ANY SIGNIFICANT LIFE CHANGES OR DISRUPTIONS ABOUT WHICH WE SHOULD BE AWARE____________________________________
____
___ANY LEARNING ISSUES__________________
____
____

STUDENT NAME___________________________
LIST ANY LONG-TERM MEDICATIONS
____
DOSAGE________CONDITION_______________
WILL IT BE TAKEN AT SCHOOL? Y___ N___
MANNER ADMINISTERED___________________
CAN CHILD ADMINISTER? Y___ N___
IF NO, WHO CAN?__________________________
OTHER HEALTH INFORMATION:
___NO KNOWN HEALTH PROBLEMS
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___EPILEPSY
___HEART CONDITION
___VISION PROBLEMS
___HEARING PROBLEMS
___ALLERGIES
FOODS______________________________
MEDICATIONS_______________________
BEE STINGS________________________
TREATMENT NEEDED________________
___ADD / ADHD___________________________
___OTHER (PLEASE SPECIFY)
____
___ANY SIGNIFICANT LIFE CHANGES OR DISRUPTIONS ABOUT WHICH WE SHOULD BE AWARE____________________________________
____
___ANY LEARNING ISSUES__________________
____
____

IF MY CHILD IS ILL OR HAS AN EMERGENCY AND I CANNOT BE REACHED, PLEASE CALL AND RELEASE MY CHILD IN ORDER OF PREFERENCE TO:

NAME____PHONE_______________________________

RELATIONSHIP_______________________________________CELL PHONE___________________________

NAME____PHONE_______________________________

RELATIONSHIP_______________________________________CELL PHONE___________________________

IN CASE OF AN ACCIDENT OR SUDDEN ILLNESS, WHEN A PARENT OR GUARDIAN IS UNAVAILABLE, I AUTHORIZE A TEMPLE OR RISHON REPRESENTATIVE TO OBTAIN MEDICAL CARE FOR MY CHILD, INCLUDING NECESSARY TRANSPORTATION, IN ACCORDANCE WITH THEIR BEST JUDGMENT. I FURTHER AUTHORIZE THE DOCTOR NAMED BELOW TO PROVIDE THE CARE AND TREATMENT HE/SHE CONSIDERS NECESSARY. IF THE PHYSICIAN DESIGNATED BELOW IS UNAVAILABLE, I AUTHORIZE SUCH CARE AND TREATMENT TO BE PERFORMED BY A LICENSED PHYSICIAN SELECTED BY THE TEMPLE REPRESENTATIVE. I AGREE TO PAY ALL COSTS INCURRED AS A RESULT OF THE FOREGOING.

MEDICAL INSURANCE PLAN______________________________GROUP #__________________________

MEDICAL/PATIENT ID NUMBER(S)____

DOCTOR NAME____PHONE_________________________

DENTIST NAME____PHONE_________________________

____ ____
PARENT NAME (PRINT) PARENT SIGNATURE

OTHER ADULTS **NOT** AUTHORIZED TO PICK CHILD UP FROM SCHOOL

NAME___________________________________ NAME____